EXHIBIT A
to Answer

Jason Reyes v. City of New York, et al., 07 CV 6349 (PC)

PRISON HEALTH SERVICES
Contracted by NYC Department of Health and Mental Hygiene

CERTIFICATION

I, Cyril Joseph, Assistant Director of Medical Records of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, hereby certify that the record of the attached is in the custody of, and is an accurate and complete record of the condition, act, transaction, occurrence or event of this program concerning:

REYES, JOSE
(Name of Patient)

[illegible]
(Book and Case Number)

I further certify that this record was made in the regular course of business of this program and it is the regular course of business of this program to make such records. The record was made at the time of the condition, act, transaction, occurrence or event recorded or within a reasonable time thereafter.
The record contained herein is a certified reproduction of the record on file (in accordance with CPLR Section 2306)

[illegible]
(Date)

C. Joseph
Cyril Joseph
Assistant Director of Medical Records

DELEGATION OF AUTHORITY

I, PETRINA MARINER, Director of Medical Records of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, certify that, **CYRIL JOSEPH, Assistant Director of Medical Records, of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene,** whose signature appears above is a responsible employee of this program. I hereby authorize him to certify records of this program as accurate and complete records of this program, such records having been made in the regular course of business of this program at the time of the condition, act, transaction, occurrence, or event recorded or within a reasonable time thereafter.

P Mariner

Petrina Mariner.
Director of Medical Records.

NYC Health

DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROBLEM LIST

Patient's Last Name	First Name
Reyes	Jason

Book & Case Number	NYSID Number
349-06-02628	0470442Y

DOB 1/13/1983

ALLERGIES: NKA

CHRONIC MEDICAL PROBLEMS	DATE LISTED
S/P LANKLE INJURY 2002 WITH NERVE DAMAGE	2/12/2006
ATYPICAL CHEST PAIN	5/25/06

PSYCHIATRIC DSM IV DIAGNOSIS	DATE LISTED

SUICIDE WATCH	DATE ON	DATE OFF

SUICIDE RISKS	DATE LISTED

INMATE HAS CONTRAINDICATIONS FOR

Category A (Chemical Agents):

Medically contraindicated if the patient has ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD)

Category B (Stun Shield):

Medically contraindicated if the patient has ANY of the following conditions: **(Check All That Apply)**

☐ Pregnancy ☐ Hypertension ☐ Pace Maker ☐ Asthma ☐ Seizure ☐ Diabetes ☐ Cardiac Disease

☒ NO CONTRAINDICATIONS

Signature: Issa Madhoun Date: 2/12/2006

NYC Health

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

INTAKE HISTORY AND PHYSICAL EXAM

PATIENT'S LAST NAME	FIRST NAME
Reyes	Jason

BOOK & CASE NUMBER	NYSID NUMBER	DOB	IS PATIENT EMANCIPATED?
349-06-02628	0470442Y	1/13/1983	☒ YES ☐ NO

DATE	TIME	FACILITY
2/12/2006	02:53 ☒ AM ☐ PM	BBKC

HAVE YOU PREVIOUSLY BEEN INCARCERATED? ☐ YES ☒ NO
If yes, where? ☐ RIKERS ☐ ELSEWHERE N/A
If yes, when? N/A

DO YOU HAVE MEDICAID OR ANY HEALTH INSURANCE? ☐ YES ☒ NO
WHERE DO YOU CURRENTLY GET MEDICAL CARE? BETH ISRAEL

1. DO YOU HAVE ANY ALLERGIES? ☐ YES ☒ NO
Reaction Type ☐ HIVES ☐ RASH ☐ SOB ☐ ANAPHYLAXIS ☐ DON'T KNOW
ALLERGIES TO MEDICATIONS? N/A
OTHER? N/A

2. HAVE YOU EVER HAD CHICKEN POX? ☐ YES ☐ NO ☒ DON'T KNOW

3. HAVE YOU EVER HAD HIGH BLOOD SUGAR OR DIABETES? ☐ YES ☒ NO
yes, Current Medications? ☐ YES ☒ NO
If yes, List on Page 2.

FINGER STICK (ON ADMISSION) N/A

4. HAVE YOU EVER HAD TB? ☐ YES ☒ NO
Where diagnosed? N/A

Do you have?
Weight loss ☐ YES ☒ NO
Night Sweats ☐ YES ☒ NO
Fever ☐ YES ☒ NO
Cough > 2 Wks ☐ YES ☒ NO

Chest X-ray done? ☐ YES ☒ NO
If yes, ☐ Normal ☐ Abnormal
When? N/A

Current and Past TB Medications Taken? N/A

How long taken? N/A

5. HAVE YOU EVER HAD:
- Multiple Sex partners? ☐ YES ☒ NO
- Unprotected sex? ☐ YES ☒ NO
- Sex with substance abusers? ☐ YES ☒ NO
- Same sex relationship? ☐ YES ☒ NO
- Injection Drug Use? ☐ YES ☒ NO

HAVE YOU EVER HAD:
- Syphilis? ☐ YES ☒ NO
- Gonorrhea? ☐ YES ☒ NO
- Chlamydia? ☐ YES ☒ NO
- Hepatitis A? ☐ YES ☒ NO
- Hepatitis B? ☐ YES ☒ NO
- Hepatitis C? ☐ YES ☒ NO

Any current tx? ☐ YES ☒ NO

Do you have HIV Infection or AIDS? ☐ YES ☒ NO
(If yes, complete HIV Flow Sheet)

6 RAPID HIV TEST
- ☐ Wants Rapid HIV Test
- ☒ Declines HIV Testing
- ☐ Undecided
- ☐ Confirmatory
- ☐ Retest

REASONS FOR DECLINING RAPID HIV TEST
- ☐ Known HIV Positive
- ☐ Prefer Conventional Test
- ☐ Had Negative HIV Result < 3 months ago
- ☒ Not Ready to get test results today
- ☐ Don't want test now/today
- ☐ Other

HIV Ab Testing done? ☒ YES ☐ NO
When? 2005

Viral Load ☐ YES ☒ NO
N/A
When? N/A

Latest T-Cell (CD4)
N/A
When? N/A

7. EVER HAD ASTHMA? ☐ YES ☒ NO
If yes, Current Medications? ☐ YES ☒ NO (List in Page 2)

Last ER Visit? N/A
Last Attack? N/A
Ever Admitted? ☐ YES ☒ NO

Ever Intubated? ☐ YES ☒ NO
When? N/A

8. EVER HAD A SEIZURE? ☐ YES ☒ NO
If yes, Current Medications? ☐ YES ☒ NO (List in Page 2)

Last Seizure? N/A

9. EVER HAD HYPERTENSION? ☐ YES ☒ NO
If yes, Current Medications? ☐ YES ☒ NO (List in Page 2)

10. DO YOU HAVE:
☐ PND ☐ SOB
☐ Palpitations ☐ DOE
☐ Pedal Edema ☒ N/A

Chest Pain? ☐ YES ☒ NO
When? N/A

Syncope? ☐ YES ☒ NO
When? N/A

Family history of sudden death under age 55? ☐ YES ☒ NO

Ever had Heart Disease? ☐ YES ☒ NO

Ever had a heart attack? ☐ YES ☒ NO
When? N/A

11. HAVE YOU RECENTLY DELIVERED A BABY? ☐ YES ☐ NO ☒ N/A
- IF YES, WITHIN THE LAST SIX (6) WEEKS? ☐ YES ☐ NO ☒ N/A
- ARE YOU PREGNANT? ☐ YES ☐ NO ☐ Don't Know ☒ N/A
- DATE OF LAST MENSTRUAL PERIOD? ☒ N/A

12. HAVE YOU HAD A MAMMOGRAM IN THE LAST 12 MONTHS? ☐ YES ☐ NO ☒ N/A
If yes, when? N/A

13. HAVE YOU HAD A PAP SMEAR IN THE LAST 12 MONTHS? ☐ YES ☐ NO ☒ N/A
If yes, when? N/A

14. DO YOU USE DRUGS? ☐ YES ☒ NO
DRUG AMOUNT: N/A

Drugs used: ☐ HEROIN ☐ BARBITURATES ☐ MARIJUANA ☐ CRACK ☐ COCAINE ☐ CRYSTAL METH ☐ METHADONE ☐ OTHER: N/A

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

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NYC 000003

Reyes, Jason - 349-06-02628

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15. ARE YOU CURRENTLY IN A METHADONE PROGRAM? ☐ YES ☒ NO
Where? N/A
Dose N/A

16. DO YOU USE ALCOHOL? ☐ YES ☒ NO
AMOUNT: N/A
Have you considered cutting down drinking? ☐ YES ☒ NO
Annoyed by people asking about your drinking? ☐ YES ☒ NO
Ever had guilty feelings about your drinking? ☐ YES ☒ NO
Ever needed a drink as an 'eye opener'? ☐ YES ☒ NO
When last drink or drug use? N/A

17. DO YOU SMOKE? ☐ CURRENT ☐ FORMER ☒ NEVER ☐ NOT ASSESSED

18. HAVE YOU EVER HAD A SCREENING ULTRASOUND OF YOUR ABDOMEN TO LOOK FOR AN ANEURYSM? ☐ YES ☐ NO ☐ DON'T KNOW ☒ N/A

19. ABDOMINAL ULTRASOUND RESULT? ☐ POSITIVE ☐ NEGATIVE ☐ DON'T KNOW ☒ N/A
When? N/A

20. HISTORY OF DENTAL PROBLEMS (pain, bleeding gums, etc.) ☐ YES ☒ NO
IF YES EXPLAIN N/A

21. HISTORY OF HOSPITALIZATION ☒ YES ☐ NO
IF YES, DESCRIBE IJJURY L ANKLE AND HEEL2002 WITH NERVE DAMAGE BETH I

22. ANY ADDITIONAL MEDICAL PROBLEMS? ☒ YES ☐ NO
List
PAIN L ANKLE ON PERCOCET PRN

23. TREATED OR HOSPITALIZED FOR NERVOUS / MENTAL PROBLEMS? ☐ YES ☒ NO
When? N/A
Where? N/A
Why? N/A

24. ARE YOU TAKING MEDICATION FOR NERVES/MENTAL PROBLEMS? ☐ YES ☒ NO
Medications / Dosage:
N/A

25. HAVE YOU TRIED TO HURT OR KILL YOURSELF? ☐ YES ☒ NO
When? N/A
How? N/A
Why? N/A

26. HAVE YOU EVER BEEN ASSAULTED (SEXUALLY/PHYSICALLY)? ☐ YES ☒ NO

27. HAVE YOU BEEN CHARGED WITH A VIOLENT ACT (RAPE, ASSAULT)? ☐ YES ☒ NO
CHARGES REVIEWED? ☐ YES ☒ NO

28. HAVE YOU HURT ANYONE WHEN YOU WERE ANGRY OR UPSET? ☐ YES ☒ NO
When? N/A
Who? N/A
How? N/A
Why? N/A

29. FAMILY HISTORY OF MENTAL ILLNESS? ☐ YES ☒ NO
If Yes, List Who:
N/A

30. FAMILY HISTORY OF SUICIDE? ☐ YES ☒ NO
If Yes, List Who:
N/A

31. HAVE YOU EXPERIENCED ANY RECENT LOSSES? (i.e., death, employment, relationships, etc) ☐ YES ☒ NO
Explain
N/A

SUMMARY OF CURRENT MEDICATIONS *(Please List)*
N/A

COMPLETED BY *(Print Name)* Issa Madhoun

REVIEWED BY: Issa Madhoun

Signature of person completing form | Title | Date | Time

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

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NYC Health

DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PHYSICAL EXAMINATION

Last Name	First Name	Temp
Reyes	Jason	98.8

Snellen's	w/o correction	w correction	Ht	Pulse
	R 20	R N/A	5' 8"	78
	L 20	L N/A		RR 14

VSS Taken by *(Full Name)* Gladys Paul — Wt 226 — Peak Flow

Signature — BP 120 / 70

GENERAL APPEARANCE: *(Include body habitus, nutritional status, and state of distress.)*

HEENT — Describe: N/A
- ☒ NL
- ☐ Traumatic
- ☐ Lacerations
- ☐ Icteric
- ☐ Scalp lesions
- ☐ Abnormal Pupils
- ☐ Conjunctivitis
- ☐ Pale sclera
- ☐ Other

SKIN — Describe: N/A
- ☒ NL
- ☐ Rash
- ☐ Pallor
- ☐ Scars
- ☐ Jaundice
- ☐ Tattoos
- ☐ Tracks
- ☐ Other

ORAL CAVITY — Describe: N/A
- ☒ NL
- ☐ Lesions
- ☐ Swellings
- ☐ Filled cavities
- ☐ Dentures loose
- ☐ Missing teeth
- ☐ Other

BREASTS — Describe: N/A
- ☒ NL
- ☐ Masses
- ☐ Discharge
- ☐ Other

CHEST — Describe: N/A
- ☒ NL
- Wheezes
- ☐ Rales
- ☐ Rubs
- ☐ Rhonchi
- ☐ Other

HEART — Describe: N/A
- ☒ NL / RRR
- ☐ Murmur
- ☐ Pub
- ☐ Gallop
- ☐ Other

FUNDUS
- ☒ Normal
- ☐ Not Visualized
- ☐ Other

OTOSCOPIC
- ☒ NL Canal
- ☐ NL TM
- ☐ Cerumen
- ☐ Abnl

LYMPH NODES — Describe: NO ADENOPATHY

NECK THYROID
- ☒ NL
- ☐ Carotid Bruit
- ☐ Thyroid enlargement/mass

ABDOMEN — Describe: N/A
- ☒ NL
- ☐ Tenderness
- ☐ Hypo/Hyperactive Bowel sounds
- ☐ Organomegaly
- ☐ Ascites
- ☐ Other

GENITALIA — Describe: N/A
- ☒ NL
- ☐ Sores
- ☐ Discharge
- ☐ Lesions
- ☐ Warts
- ☐ Other

PELVIC EXAM *(Adnexa, Uterus)* — Describe: N/A
- ☒ N/A
- ☐ NL
- ☐ Discharge from Cervix
- ☐ Uterine Mass
- ☐ Refused
- ☐ Adnexal Mass
- ☐ Tenderness
- ☐ Other

PAP SMEAR — Describe: N/A
- ☐ Performed
- ☐ Refused
- ☐ Chlamydia/Gonorrhea Test
- ☐ Deferred
- ☐ Culture
- ☐ Other *(Describe)*

RECTAL — Describe: N/A
- ☐ NL
- ☐ Hemorrhoids
- ☐ Fissures
- ☐ Warts
- ☐ Not Indicated Pt less than 40 yrs old
- ☐ Sores
- ☒ Refused
- ☐ Other

EXTREMITIES — Describe: TENDERNESS L ANKLE SENSORY LOSS L HEEL
- ☐ NL
- ☐ Edema
- ☐ Cyanosis
- ☐ Pulse
- ☐ Clubbing
- ☒ Other

MENTAL STATUS

ORIENTATION TO
- ☒ Time
- ☒ Place
- ☒ Person

PSYCHOMOTOR
- ☒ WNL
- ☐ Retardation
- ☐ Agitation

SPEECH
- ☐ Coherent
- ☐ Incoherent
- ☒ Normal Rate
- ☐ Pressured
- ☐ Spontaneous

MOOD
- ☒ Euthymic
- ☐ Anxious
- ☐ Depressed
- ☐ Embarrassed/Humiliated
- ☐ Irritable
- ☐ Elated
- ☐ Angry

AFFECT
- ☒ Appropriate to mood
- ☐ Inappropriate to mood
- ☐ Labile

THOUGHT PROCESS
- ☒ Logical
- ☐ Illogical
- ☐ Relevant
- ☐ Irrelevant

ANY PROBLEMS WITH SLEEP OR APPETITE OR ANY FEELINGS OF HOPELESSNESS OR BEING WORTHLESS?
☐ YES ☒ NO
N/A

SUICIDAL IDEATION? ☐ YES ☒ NO
N/A

HOMICIDAL IDEATION? ☐ YES ☒ NO
N/A

DELUSIONS
- ☒ None
- ☐ Grandiose (Do you have special abilities or features?)
- ☐ Persecutory (Do you feel anyone is plotting against you?)
- ☐ Somatic
- ☐ Other

HALLUCINATIONS Does patient exhibit any?
- ☒ None
- ☐ Auditory
- ☐ Visual

DOES PT EXHIBIT ANY SIGN OF GROSS MENTAL RETARDATION?
☐ YES ☒ NO

NEUROLOGIC *(Sensory, Motor, DTR, Gait, Cerebellar, Cranial Nerves)*
SENSORY DEFICITIS L HEEL

DESCRIBE *(If abnormal, give details in assessment)*

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

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DATE PPD IMPLANTED	RESULT	DATE READ	INITIAL
2/12/2006	00mm	2/14/2006	dobsonkd

IMMUNIZATION	DATE

LABORATORY DATA	DATE ORDERED	RESULT
PPD	2/12/2006	00mm
RPR	2/12/2006	Ne
Dipstick	2/12/2006	wnl
STD Urine Screen	2/12/2006	My Myc

RADIOLOGY/TYPE	DATE ORDERED	DATE PERFORMED	RESULT

FOLLOW-UP/CONSULTS	DATE ORDERED	CLINIC	FACILITY	DATE SEEN
Nursing Followup - Read PPD	2/12/2006	PPD Read	BBKC	
Nursing Followup - HIV Rapid Refused	2/12/2006	HIV Rapid Refusal	BBKC	
Medical Followup - PAIN L ANKLE S/P INJURY 2002	2/12/2006	Injury	BBKC	
PT	5/4/06	PT	MLC 03	5/06
NPMR 5/3 6 X	4/18/06			
PT	5/17/06	PT	MLC 03	

MEDICATION LIST

START DATE	MEDICATION	DATE DISCONTINUED
2/12/2006	Motrin - Tab - 400MG - BID	2/16/2006

[redacted]

Patient's Name

REYES, JASON 00000000
252 50TH ST 3
NY, NY 11220
13-JAN-83 O Y M 5'8" 216 BRO BLK
NY C
LOPICKELOW, ROE
1866 60TH ST 3, NY, NY FI
3490602628 0470442Y 11-FEB-06

Book & Case Number | NYS ED ID | Facility

ALLERGIES

DATE LISTED	PROBLEMS	PLAN	DATE RESOLVED
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	7.		
	8.		

CONSULTS

DATE ORDERED	CLINIC	FACILITY	DATE SEEN

RADIOLOGY

DATE ORDERED/TYPE	DATE PERFORMED	RESULT

LABORATORY

	DATE DONE	RESULT	DATE DONE	RESULT	DATE DONE	RESULT
SEROLOGY						
URINE D.S.						
CBC						
ASI/ALT						
GC : (O/G/A)						
Other:						

TREATMENTS

DATE	TYPE/TREATMENTS

INMATE HAS CONTRAINDICATIONS FOR:

☐ CATEGORY A (CHEMICAL AGENTS)*
Medically contraindicated if the patient has any of the following conditions (check condition)
☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD)

☐ CATEGORY B (STUN SHIELD)*
Medically contraindicated if the patient has any of the following conditions (check condition)
☐ Pregnancy ☐ Hypertension ☐ Pace Maker ☐ Asthma
☐ Seizure ☐ Diabetes ☐ Cardiac disease

☐ NONE

DATE SIGNATURE

PPD

DATE DONE	RESULT	DATE READ	SIGNATURE	IMMUNIZATION	DATE
_/_/_		_/_/_			_/_/_

INH

DATE STARTED	DATE COMPLETED	DATE STOPPED	DATE DOH NOTIFIED
_/_/_	_/_/_	_/_/_	_/_/_

EKG

☐ Normal
☐ Abnormal

DHS . 89 Rev 4, 04)

Patient chair coming From C-76

Needs Wheel Chair

PRE – ADMISSION FORM
Dorm 2B

DATE ACCEPTED: 4/17/06 DATE ARRIVED: _____

TIME ACCEPTED: 12:47 pm TIME ARRIVED: _____

PATIENT'S NAME: Reyes Jason

B & C # OR DATE OF BIRTH: 3490602628

REFERRING PHYSICIAN: Dr. Hayman

REFERRING FACILITY: Bellevue hosp.

REQUESTED ADMISSION DATE: 4/17/06

M.D. OR PHYSICIAN ACCEPTING PATIENT: R. Lehm MD

ced
a-1
5' 8"
118/78
86
16
98

NOTE: THIS PRE-ADMISSION FORM IS VALID FOR 48 HOURS!

DEPARTMENT OF CORRECTION ACTION

CONFIRMED BY: _____
TITLE NAME SHIELD #

COMMAND: _____

DATE: _____ TIME: _____

NOTE: ALL INMATES TO THE INFIRMARY AREAS (DORM1, 2A, 2B AND 4) MUST HAVE A PRE – ADMISSION FORM. INMATES TO NON – INFIRMARY AREAS (NIC MAIN AND DORM 3) FROM OTHER INSTITUTIONS PRINCIPAL HOSPITAL DOES NOT REQUIRE A PRE – ADMISSION FORM.

Reyes, Jason - 349-06-02628

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ADDITIONAL COMMENTS *(Please include Question Number with each Additional Comments Section)*

ASSESSMENT	PLAN
S/P LANKLE INJURY 2002 WITH NERVE DAMAGE	[illegible]GE GIVEN CANEF/U PRN

DISPOSITION

Medical Isolation Reason

N/A

☐ Detox

N/A

HOUSING : ☒ GP ☐ CDU ☐ INFIRMARY ☐ C-71 ☐ MO ☐ OTHER:

CONSULTS: ☐ URGICARE ☐ ER/HOSPITAL ☐ MH EMERGENCY ☐ MH ROUTINE ☐ OTHER:

BROCHURES GIVEN?

REACH HIV-STD	☐ YES	☒ NO
Health Information	☒ YES	☐ NO
Dental Brochure	☐ YES	☒ NO

SIGNATURE	DATE/TIME
	2/12/2006 3:41 AM
PRINT NAME	TITLE
Issa Madhoun	

REVIEWED BY: Issa Madhoun — 2/12/2006 3:41 AM

PRINT NAME — SIGNATURE — DATE/TIME

Please use the Additional Comments area on the top of this page for any "YES" question requiring additional space.

2/12/2006 3:43:48 AM

PATIENT ACCEPTANCE NOTE
NIC

Dorm 2B
Referring MD/PA Dr. Hayman Date
Referring Facility: Bellevue hosp Telephone #
1. Patient: Reyes Jason Date of Birth
Book and Case Number: 3-490602 NYSID:
2. Diagnosis / Reason for Infirmary Care: Dysphony Reflux sympathetic

3. History of Illness (use other side if more room needed):

4. Other considerations: Date of last fever:
Abnormal mental status? D
Ambulation status? Wheelchair bound Incontinence?
Nursing needs? (dressings, catheters, feeding, turning, etc.) D

5. Labs: PPD & Date: CXR & Date:
Special (CT's, LPs, etc.)
Pertinent blood results

6. Medications (doses, frequency, when to stop):

7. Follow-up needed: D INH / Date?
8. If MH/Nursing / Chief MD approval needed*, who contacted / when?
9. Accepted by: Dr Lim (MD) / PA Date: 4/17/06

* If high level nursing care needed, contact CNA, PCC or nurse in charge; if psychiatric disturbance, contact Mental Health

Form #1097 3/98

NYC HEALTH AND HOSPITAL CORPORATION
CORRECTIONAL HEALTH SERVICES

INFIRMARY ADMISSION HISTORY AND ASSESSMENT

SECTION I

INFIRMARY: Nic D2A | NAME: Reyes, Jason | ADMITTING DATA:

DATE: 4/18/06 | TIME: 7Am. | ID#: 349 06 02628 | ADMITTING NURSE: B. Jacks

REFERRAL SOURCE: GMC/Bellevue | DOB: __/__/__ | SEX: ☑ M ☐ F | INTERPRETER: ☐ YES ☑ NO

MEDICAL DIAGNOSIS: Reflex Sympathetic Dystrophy. | LANGUAGE USED: English

PRESENT HEALTH HISTORY: | RELIGION:

PAST HEALTH HISTORY:

PREVIOUS HOSPITALIZATION: ☐ NO ☑ YES (SPECIFY):

ADDICTIVE HABITS. TOBACCO: ☐ NO ☐ YES # PACKS/DAY X # YEARS: ☐ NO ☐ YES ALCOHOL: ☐ NO ☐ YES # DRINKS/DAY:

ILLICIT DRUGS: ☐ NO ☐ YES (SPECIFY): METHADONE MAINTENANCE PROGRAM: ☑ NO ☐ YES

ALLERGIES: ☐ NONE KNOWN ☐ YES (SPECIFY):

SPEECH: ☐ SLURRED ☐ APHASIA ☑ NO PROBLEM ☐ OTHER: HEARING: ☐ IMPAIRED ☐ RT ☐ LT ☐ HEARING AID ☐ RT ☐ LT

VISION: ☑ NO PROBLEM ☐ IMPAIRED ☐ RT ☐ LT ☐ GLASSES ☐ CONTACT LENSES ☐ ARTIFICIAL EYE ☐ RT ☐ LT ☐ ENUCLEATION ☐ RT ☐ LT

DENTURES: ☐ UPPER ☐ LOWER ☐ PARTIAL ☐ NONE DIET: FLUIDS:

ACTIVITY STATUS: ☐ AMBULATORY ☐ AMBULATORY WITH ASSIST ☐ TRANSFER WITH ASSIST ☐ BED REST

ASSISTIVE DEVICES: ☐ CANE ☑ WHEELCHAIR ☐ WALKER ☐ CRUTCHES ☐ PROSTHESIS ☐ NONE ☐ OTHER:

SELF CARE STATUS:	INDEPENDENT	ASSIST	DEPENDENT
FEEDING	☑	☐	☐
BATHING	☑	☐	☐
GROOMING	☑	☐	☐
DRESSING	☑	☐	☐
TOILETING	☑	☐	☐

ADVANCE DIRECTIVES: ☐ NONE ☐ YES (SPECIFY):

INCONTINENT ☐ NO ☐ YES (SPECIFY):

MEDICATION ☐ NONE

DRUG	DOSE	FREQ	LAST DOSE TAKEN	REASON
			☐ AM ☐ PM	
			☐ AM ☐ PM	
			☐ AM ☐ PM	
			☐ AM ☐ PM	
			☐ AM ☐ PM	
			☐ AM ☐ PM	
			☐ AM ☐ PM	

IMMUNIZATION	DATE

TB-DRUG THERAPY

START DATE	COMPLETE DATE	STOP DATE	DOH NOTIFIED	DATE CXR

VITAL SIGNS

TEMP	PULSE
RESP.	BP
HEIGHT	WEIGHT
VISUAL SCREEN	
Nurse's Signature/Title	

Form A1108/Front 6/98

NYC 0000012

DATE	LIST #	INIT	FOCI/NURSING DIAGNOSES	GOALS/DESIRED OUTCOMES	NURSING INTERVENTION	DATE	INIT	EVALUATION
4/17	1		Risk for injury RT difficulty ambulating	- no injury while in care.	- Provide w/c for mobility - Provide assistance when necessary - medicate for pain as ordered.			
4/17	2		Altered comfort/ pain RT trauma to lower extremity.	- Pain minimized / controlled while in care.	- medicate for pain as ordered - avoid further trauma - exercise safety precaut			

DATE ORDER	REFERRALS / CONSULTS	DATE DONE	DATE ORDER	SPECIMENS	DATE SENT	DATE ORDER	EKG / X-RAY / DIAGNOSTIC TESTS	DATE DONE

NAME_____ ID #_____ BED LOCATION_____

CHILDHOOD APPLIED BEHAVIOR ANALYSIS, INC. (CABA)

RESPIRATORY: ☐ cough ☐ sputum ☐ no ☐ yes describe ____
☐ dyspnea ☐ orthopnea ☐ cyanosis ☑ none
COMMENTS:

CARDIOVASCULAR: ☐ chest pain ☐ palpitations ☐ varicosities: ____
☐ poor circulation to extremities ☐ edema: ____ ☑ none
COMMENTS:

GASTROINTESTINAL: ☐ nausea ☐ vomiting ☐ anorexia ☐ dysphagia ☐ bleeding
☐ hemorrhoids ☐ weight loss: ____ ☐ weight gain: ____ ☐ diarrhea: ____
☐ constipation: ____ ☐ freq. of BM: ____ ☐ ostomy: ____ ☑ none
COMMENTS:

GENITO-URINARY: ☐ dysuria ☐ hematuria ☐ retention ☐ nocturia ☐ frequency
☐ ostomy: ____ ☐ catheter: ____ ☐ dialysis: ____ ☑ none
COMMENTS:

MALE: ☐ prostrate enlargement ☐ urethral/penile discharge ☐ no ☐ yes (specify) ____
☐ lesions ☐ no ☐ yes STD: ☐ no ☐ yes (specify): ____
COMMENTS:

FEMALE: LMP: N/A pregnant: ☐ no ☐ yes pregnancies: ____ miscarriages: ____
abortions: ____ live births: ____ birth control: ☐ no ☐ yes: ____
pelvic/tube infection: ☐ no ☐ yes vaginal discharge: ☐ no ☐ yes: ____
lesions: ☐ no ☐ yes STD: ☑ no ☐ yes (specify): ____
COMMENTS:

BREAST: masses: ☐ no ☐ yes discharge: ☐ no ☐ yes: ____ BSE: ☐ no ☐ yes
COMMENTS:

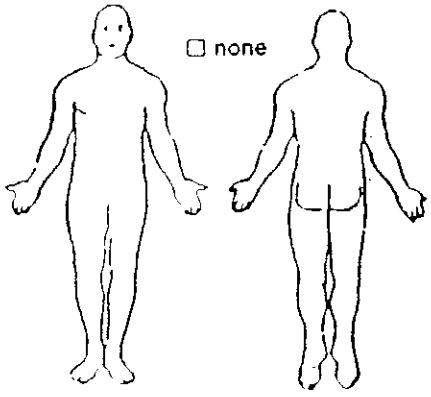
MUSCLO-SKELETAL: ☐ arthritis ☐ paralysis: ____ ☐ paresis: ____ ☐ amputation: ____
☐ contractures: ____ ☐ deformity: ____ ☐ fracture: ____
COMMENTS:

NEUROLOGICAL: headaches: ____ vertigo syncope tremors seizures: ____
sensory/motor impairment: ____ oriented (person) (place) (time)
COMMENTS:

PAIN: location: type: onset: duration: ☐ none

SKIN: temperature: ☐ warm ☐ cold ☐ moist ☑ dry turgor: ☑ good ☐ poor
hair: ____ nails: ____
COMMENTS:

Identify on diagram site of the following:
A = bruises, B = masses, C = scars, D = lesions, F = wounds
and D = decubitis (describe size, shape, stage)



EDUCATIONAL NEEDS: ____
DISCHARGE PLANNING: ____
WHERE WILL YOU GO WHEN DISCHARGED: ____
ANYONE TO ASSIST YOU AFTER DISCHARGE: ____
PLAN OF CARE: ____ EXPLAINED: ☑ YES ☐ NO EXPLAIN: ____
ORIENTATION TO ENVIRONMENT: ☑ YES ☐ NO EXPLAIN: ____
SIGNATURE/TITLE OF DATA COLLECTOR: ____
RN REVIEWER: ____ DATE: 4/12/06 TIME: ____

Form RI108/Back 6/

NYC HEALTH AND HOSPITAL CORPORATION
CORRECTIONAL HEALTH SERVICES

DEPARTMENT OF NURSING

INFIRMARY CLINICAL ACTIVITY FLOWSHEET

PATIENT'S NAME: Reyes Jason

I.D.#: 349-06-02628

AGE/D.O.B. ____________ SEX: ✓ M ___ F

AREA: NIC D. 2A

DATE	4-18-06		4/19		20		21	22	23	24
TIME	10A	pp	10A	pp	10A		10A	10A	10A	10A
TEMPERATURE (104°–96°)										
PULSE	84	88	66	82	72		82	84	82	62
RESPIRATION	18	18	16	18	14		20	16	16	16
BLOOD PRESSURE	110/80	110/80	100/80	130/70	120/90		122/80	120/80	120/80	120/64
WEIGHT										
N/A INITIALS	[illegible]	RJ	[illegible]	PP	PJ		[illegible]	[illegible]	[illegible]	[illegible]

FLUIDS

INTAKE C.C.: ORAL / OTHER / TOTAL

OUTPUT C.C.: URINE / OTHER / TOTAL

TIME	10A	9A	10A	10A	10A
NUTRITION — DIET: TYPE	R E	G	U	L	A R
CONSUMED: ALL					
1/2					
1/4					
NONE					
SUP. FEEDING					
NG FEEDINGS					
Q ____ HR.					
MENTAL STATUS — ALERT	✓	✓	✓	✓	✓
ORIENTED	✓	✓	✓	✓	✓
OTHER					
SAFETY — ↑ SIDE RAILS = UP	✓				
↓ = DOWN					

⦿ = ABNORMAL FINDINGS, (R) = REFUSED AND O = OUT TO COURT MUST BE CIRCLED IN RED
✓ = NO CHANGE / DONE
★ = SEE PROGRESS NOTES
BLANK = NOT APPLICABLE

Form MM014/Front

INFIRMARY CLINICAL ACTIVITY FLOWSHEET

DATE:	4/18	4/19/06	4/20/06	4/21/06	4/22	4/23	4/24	
TIME:		6AM	4P	6A	4P	4P		
ISOLATION: RESPIRATORY								
ENTERIC								
OTHER measles		✓	✓	✓	✓	✓	✓	
SELF CARE: BATH COMPLETE: PARTIAL: SELF		✓	✓	✓	✓	✓	✓	
MOUTH CARE		✓	✓	✓	✓	✓	✓	
FOLEY / PERI								
FOOT CARE								
ACTIVITY: BEDREST								
TURNED & POSITION								
DANGLE								
COMMODE								
BED / CHAIR								
BRP								
AMBULATE W / ASSIST		w/c	w/c	w/c	w/c	w/c	w/c	
AMBULATORY								
ELIMINATION: CONTINENT / INCONTINENT		✓	✓	✓	✓	✓	✓	
FOLEY								
SUPRA PUBIC								
CATHA								
B.M.								
OTHER								
SLEEP: SATIS - FACTORY		✓	✓	✓	✓	✓	✓	
UNSATIS - FACTORY								
THERAPY: PHYSICAL THERAPY								
PENTAMADINE								
SPUTUM								
I.V. LINES: TYPE AND SITE:								
DRESSING CHANGE Q								
TUBING INITIALS Q								
NURSE INITIALS								

INITIALS	SIGNATURE	TITLE	INITIALS	SIGNATURE	TITLE
PT	Pauline Tabern, NA				
		RN			

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THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Reyes Jason
3490602628
DOB 1/13/83

DATE	OBSERVATIONS
2/17/06 BBK Mitts 915pm	No chart F/u old LT ankle injury S/ 22y/o ♂ c hx of LT ankle neurological damage s/p 2002 trauma presents stating minimal pain relief c qd Motrin O/ R16 P80 ambulates c cane + limp LT ankle - atrophy, ↓ ROM, scars s/p old LT ankle injury c motor limitation x 4yrs A/ - Naproxen / Tylenol advocated on meds - f/u s/c prn Consider adding Tylenol #3 if no relief Jacques Lorthe H, RPAC Reviewed MD

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CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

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Reyes Jason
3F9060 2628
DOB 1/13/83

DATE	OBSERVATIONS
2/13/06 BM	S- Request Note for Cane O- H/O Ankle Injury A/P Note for Cane given to pt F/U in 3 months in sick call F I S - Ira Gornish, RPA Christian Pedestru
2/28/06 MH 10:15	Medical note called in for Wellbutrin which renewed - Orders expired - few days ago Orders written for 5 days NTC PRN Franklin Mejia, MD
BBLC 3/20/06 MH 8:57am	S/C S/ 22 y/o ♂ c old LT ankle injury c subsequent sensory/motor dysfxn. pt requesting renewal of cane O/ RIY WD LT ankle - drsm, & clean, vascular intact A/ 22 y/o ♂ c old injury LT ankle motor dysfxn P/ DOC (with cane permit) F/U S/C PRN referral - s/p 30 days Jacques Lontke Jr, RPA Cristian Pedestru, MD

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CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

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Reyes Idrian
34906626 28
1/13/83

DATE	OBSERVATIONS
3/28/06	S/C
BBK	S/ 23 y/o ♂ c hlo RSD presents
MIM	c pain management Regimen
1504pm	letter provided by his PMD
	Dr Germaine M, Reeve M.D.
	Faxed on 3/20/06. Pt currently
	on clo T pain, intensity
	of RUE RSD
	ambulates slowly c a cane
	at stable ♂ c h/o RSD to left
	lower extremity.
	pt-for clinic 3/29/06 for MD
	pain meds review + evaluation
	- Copy of pt chart will be made

Benjamin Hamilton, M.D., F.A.C.P.

LANDIS BARNES, D.O.

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CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

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Reyes, Jason
349-06-02628
BBKCH

DATE	OBSERVATIONS

Redacted

3/30/06 S/P (R) ankle injury. Ambulates c cane - c/c pain -
SOA - See Trauma notes
P Naproxen 500mg BIDxSD
Robaxin 500mg BIDx7D
F/U PRN.

Celia Tindale, RPA
Franklin Mejia, MD

CHS 288 (Rev 3/05)

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DIVISION OF HEALTH CARE ACCESS AND CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

REYES, JASON 00000000
252 50TH ST 3
NY, NY 11220
13-JAN-83 O Y M 5'8" 216 BRO BLK
NY C FI
LOPICKELOW, ROE
1866 60TH ST 3, NY, NY
3490602628 0470442Y 11-FEB-06

EVERY ENTRY MUST BE DATED AND S

DATE	OBSERVATIONS
4/12/06 EmTC 8:15p	S- Pt seen in clinic for s/c call - c/o difficulty c ambulation. States "I have this problem for 4 yrs." O - TPR 99.8. 88. 18. BP: 128/74. Pt able to stand up c assist. Significant ambulating. Muscle twitching noted. A - Unsteady gait. Difficulty ambulating P - Referred to MD for further eval. [illegible] PA
4/13/06 C76 8:45p/Pa	S/P (L) ankle injury (4y). Patient ambulating c severe difficulty even c walking cane help. Has been able to stand but c assistance VS stable HX of RSD (reflex sympathetic dystrophy). see above VS. ATTEMPT TO TRANSFER PATIENT TO NIC; NO BED AVAILABLE AS PER D= SINGA. Patient given crutches to help in ambulating. PTC card given for F/U in AM (4/14/06). [illegible] MD

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DIVISION OF HEALTH CARE ACCESS AND IMP
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

REYES, JASON 00000000
252 50TH ST 3
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13-JAN-83 O Y M 5'8" 216 BRO BLK
NY C
LOPICKELOW, ROE FI
1866 60TH ST 3, NY, NY
3490602628 0470442Y 11-FEB-06

EVERY ENTRY MUST BE DATED AND SI...

DATE	OBSERVATIONS
4/14/06	Flu
EMTC 7M	Asked by SMD to transfer Pt to NIC
11:45 am	Faxed documentation from Pur MD
	the RSD (Reflex Sympathetic Dystrophy also known as
	Complex. Regional Pain Syndrome
	Pt presented to NIC last night. denied commission 2° meds.
	Pt housed on main floor and given control but still needs assistance with dressing. Also unsteady on feet making it difficult to do ADL's
	① T 99.3 BP 130/78 P 72 RR 16
	Pt ambulates ↓ crutches but needed assistance getting up from the chair
	① RSD (Reflex Sympathetic Dystrophy
	② Call to NIC - Spoke ↓ Dr Georges - states not a candidate Also states there are no beds
	SMD made aware
	Flu 4-12 shot to resch NIC
	Glenda Stream, PA
4/14/06 EMTC	Multiple attempts made to fully ↓ SMD or administrator at NIC failed. Dr Glickman was informed about the problem and also about the need for NIC bed.
	Case will be endorsed for the 4-12 MD after Dorm-3 admission
	Jean Lautaud, MD

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DATE	OBSERVATIONS
4/14/06 CT6 9Bx	Patient Transfer to DORM 3 for medical reasons NO BED IN NIC - DOC NOTIFIED Gabriel Jean Louis, MD
4/19/06	MD-NIC
	c/o Pain
	Restart 800 mg PO Start + 7 DAY rdo
	NIC
4/21/06 NIC D3 11 Am	s/c
	Pt c/o pain in (L) foot. pt on pain medication and will want pain management to follow-up.
	V/S - stable
	(L) foot - no swelling or redness NL pulse bilat
	A/p - s/p (L) foot injury Cont - Current management Neurology FU
	Harjinder Bhatti, MC
	Younnean Sayah, RPA

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CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

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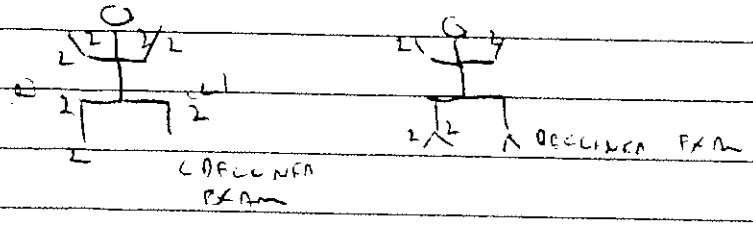
REYES, JASON
3490602628

DATE	OBSERVATIONS
5/12/06	SC IFM PT NOTE
NIC O_2	QUESTION OF MEDICATIONS C/O CONSTIPATION
12455	23 YO PMH, REFLEX SYMPATHETIC DYSTROPHY
	2° TRAUMA (L) HEEL allo/o LIMITED MOBILITY
	SYMPS PSD DEVELOPED WITHIN 3 to 4 MTHS
	PAIN (L) LEGS NUFFS (R) HIP
	WHEEL CHAIR SINCE 4/17/06
	PAIN + WEAKNESS TO LEGS
	FOLLOWED BY DR ZHUSTER SI STATIN ISCANI
	DX AT LIMITED MOBILITY MRSA iso2 OR R SC HOE
	T 95° P72 R14 P72
	NECK SUPPLE
	NO CERVICAL NODES
	PHARYNX clear TM clear
	LUNGS FOR NORMAL
	HEART RR S1 S2
	LUNGS CTA
	ABD BS NORMAL soft NON tender



SLIGHT DECREASE SIZE (L) CALF VS R)
TRACE EDEMA FOOT
CHRONIC SLIGHT HYPERPIGMENTATION
MEDIAL ASPECT SLIGHT HYPERPIGMENTATION

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DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

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REYES, JASON
349060762 8

DATE	OBSERVATIONS
5/2/06	A) Dx REFLEX SYMPATHETIC DYSTROPHY INTURA (L) HEEL 4/02 CHRONIC LOWER EXTREMITY PAIN P) ↑ NEURONTIN 800 mg PO TID x 14d - COLACE 200 mg PO QD x 30d - LIDOCAINE PATCH TO LOWER EXTREMITY QD x 14d - OXYCONTIN SR 20 mg PO BID x 7d CYMBALTA 60 mg PO QD x 7d PROVIGIL 200 mg PO QAM x 7d PT FOR MOBILITY IF IC, INSTRUCTIONS Tarjinder Bhatti, MD Thomas Schwaner, PA